MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

P.O. BOX 58
JEFFERSON CITY, MO 65102-0058

REPORT OF INJURY

(To complete form, see attached instructions)

GENERAL

EMPLOYER *(NAME, ADDRESS, INCL ZIP CODE)*

CARRIER ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYERS LOCATION ADDRESS *(IF DIFFERENT)*

LOCATION #

PHONE #

SIC CODE

EMPLOYER FEIN

CARRIER / CLAIMS ADMIN

CARRIER *(NAME, ADDRESS & PHONE NO.)*

POLICY PERIOD to

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR *(NAME, ADDRESS & PHONE NO.)*

CARRIER FEIN

INSURANCE POLICY NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME *(LAST, FIRST, MIDDLE)*

DATE OF BIRTH

SOCIAL SECURITY #

DATE HIRED

STATE OF HIRE

ADDRESS *(INCLUDE ZIP)*

SEX
☐ MALE
☐ FEMALE
☐ UNKNOWN

MARITAL STATUS
☐ UNMARRIED
SINGLE DIVORCED
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OCCUPATION JOB TITLE

EMPLOYMENT STATUS

PHONE #

OF DEPENDENTS

NCCI CLASS CODE

WAGE

RATE PER ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER

OF DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY / ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME PHONE NUMBER

TYPE OF INJURY ILLNESS

PART OF BODY AFFECTED

DID INJURY ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

ZIP CODE OF THE LOCATION WHERE THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.

CAUSE OF INJURY CODE

DATE RETURN TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN HEALTH CARE PROVIDER *(NAME & ADDRESS)*

HOSPITAL *(NAME & ADDRESS)*

INITIAL TREATMENT
☐ 0 - NO MEDICAL TREATMENT
☐ 1 – MINOR: BY EMPLOYER
☐ 2 – MINOR CLINIC HOSPITAL
☐ 3 – EMERGENCY CASE
☐ 4 – HOSPITALIZED > 24 HOURS
☐ 5 – FUTURE MAJ. MED. LOST TIME ANTICIPATED

OTHERS

WITNESS *(NAME & PHONE #)*

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

NOTE > This form is both the notice and report of injury as required by Section 287.380, RSMo. Injuries that require only first aid and result in no lost time need not be reported. Please mail this report to your WORKERS' COMPENSATION INSURANCE CARRIER or Claims Administrator. If you are self-insured or are not under the Law and do not have an insurance carrier, mail this form to the Division.

PRINT QUALITY > All reports of injury and supporting documents received by the Division will be processed electronically. All forms submitted to the Division MUST be of clear and legible quality. Handwritten forms will not be accepted. Computer generated forms shall use a **minimum** type size of **10 points**. All documents not meeting the above criteria will be returned.

TO BE ANSWERED ONLY IN CASE OF DEATH

DATE OF DEATH

EMPLOYEE'S DEPENDENTS

NAME OF DEPENDENT	RELATION TO EMPLOYEE	ADDRESS OF DEPENDENT			
		ADDRESS	CITY	STATE	ZIP CODE